Kansas Department of Health and Environment

Adult Care Home Program

FACT SHEET

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In this issue....

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Implementation of MDS 2.0

The implementation date for the MDS 2.0 has been deferred until July 1, 1997. This decision was reached in consultation with the Department of Social and Rehabilitation Services and provider organizations. The proposed training schedule for facility staff has been amended to reflect this date.

Two workshops will be held in November for administrators, consultants and corporate staff. This training will focus on how to select appropriate hardware and software for your facility. Faculty will include staff from the Kansas Department of Health and Environment, the Kansas Department of Social and Rehabilitation Services and Myers and Stauffer. Information will be available related to electronic transmission of the MDS data. The Kansas Professional Nursing Home Administrators Association has agreed to take the lead responsibility for organizing the two workshops. The location and dates of the workshops as follows:

Hutchinson	November 6
Topeka	November 14

Workshops for clinical staff will be held in the spring of 1997. At least eight workshops are planned for nursing facilities. A separate workshop will be held for nursing facilities for mental health. The Kansas Health Care Association and the Kansas Association of Homes and Services for the Aging have agreed to assist the department in providing these workshops.

Each licensed nursing facility and all distinct part units of licensed hospitals participating in the Medicaid and/or Medicare programs will be provided ONE copy of the revised **Resident Assessment Manual Version 2.0**. Facilities may choose to copy the manual provided by the department or purchase additional manuals from vendors. Facilities are encouraged to purchase vendor manuals which are exact duplicates of the federal manual. Some vendors have added additional material or have not followed the page numbering system found in the federal manual.

These changes may make it difficult for staff to find specific pages and information during training or when calling KDHE.

Medicare Fraud and Abuse

The United States General Accounting Office published a monograph on fraud and abuse of Medicare residents in nursing facilities. The report indicated that most providers are honest and bill appropriately. However, a wide variety of provider types including durable medical equipment suppliers, laboratories, physicians, optometrists, and psychiatrists have been involved in fraudulent and abusive billing of Medicare services and supplies furnished to nursing facility residents.

Investigations have identified that some nursing facilities make resident records available to outside providers who are not responsible for the direct care of the resident. This practice is contrary to both federal and Kansas regulations which prohibit such inappropriate access. This practice has occurred in Kansas. Facilities must not provide access to resident records to any individual who is not responsible for the resident's care in the facility. The resident or the resident's legal representative must give specific consent to individuals other than employees of the facility or health care professionals who provide services under the written order of the resident's physician before allowing access to a resident's clinical record.

Suspected Medicare fraud can be reported to the Medicare Hotline Number: 1-800-638-6833.

CARE Program

Included with this issue of the *Fact Sheet* is a letter which was sent to all nursing facility administrators from the Kansas Department on Aging. KDOA requested that the letter be included with this issue. Please ensure that all appropriate staff have an opportunity to read this important information.

Credentialing Update

Licensing of speech-language pathologists and audiologists (SLP/A): This licensure became law when KSA 65-6501 through 65-6512 became effective January 1, 1992. Employers of SLP/As must assure that employees practicing as SLP/As or holding themselves out to be SLP/As or other such titles are duly licensed. Employees who plan to engage in their supervised post-graduate professional experience must obtain a temporary license before they begin their supervised experience.

Ultimately, however, it is the responsibility of each individual licensee or candidate for licensure to obtain and maintain a valid license to practice this profession.

The statutes and rules and regulations governing the licensing of speech language pathologists and audiologists are available from the Kansas Department of Health and Environment. Requests or questions concerning licensure may be answered by contacting Health Occupations Credentialing, Mills Building, Suite 400-B, 109 W 9th, Topeka, Kansas 66612-2218, phone: (913) 296-0061 or FAX (913) 296-7025.

Employment Verification Update: The nurse aide employment verification forms have been coming into the office and Credentialing staff would like to thank all of the facilities and associations that have contributed to this process. Credentialing has fielded many calls on this process, and attached to this update is a list of the most commonly asked questions with answers provided.

Several positive factors have resulted from the employment verification process: 1) Current names, addresses and social security numbers have been updated. The registry operator is able to verify nurse aides much faster due to this additional information. This is a benefit to facilities as less time is spent getting confirmations, which has allowed the registry operator to receive 20-60 more calls **a day**. This would not have been possible a year ago. 2) It has enabled this office to discover fraudulent certificates. 3) At least 100 certified nurse aides (CNAs) have been added to the registry that originally missed grandfathering into the program. 4) Several nurse aides with confirmed abuse records were found working in facilities. 5) Several CNAs that are also certified medication aides (CMAs) or home health aides (HHAs) had separate entries on the

registry for each certificate. This process has helped us consolidate this information.

As a reminder to adult care homes, K.S.A. 39-936(c)(5) states "No adult care home shall use an individual as an unlicensed employee of the adult care home who provides direct, individual care to residents and who does not administer medications **unless** (emphasis added) the facility has inquired of the state registry as to information contained in the registry concerning the individual." Credentialing has learned of several instances of nurse aides working that were not confirmed by the registry. This practice is in violation of state statutes and regulations.

Facility inservices are **not** considered evidence of performing nursing or nursing-related tasks for the purpose of maintaining eligibility as a CNA under federal requirements.

Nurse/Home Health/Medication Aide Training Sponsorship Program: The Nurse, Home Health and Medication Aide Training Sponsorship Program has been implemented as a pilot project beginning August 1, 1996 to July 31, 1997. A training workshop was presented by Eric Aspegren in Wichita at the Kansas Vocational Association (KVA) annual conference. One community college has already received approval to offer the courses under the program and several other schools have submitted applications that are in review. Call this office at (913) 296-0056 for the final version of the program manual and send in your applications to be a part of this program.

Credentialing staff would like to thank Toni Spieth with the Kansas Vocational Association (KVA) and Lois Mallory and her staff at Wichita Area Technical College for their help with the training workshop at the KVA annual conference in July. Toni offered time for the presentation during their busy conference, and Lois and her staff were very helpful with meeting the needs before, during and after the presentation. Thank you all for your support!

Activities Directors/Social Service Designees: Activities directors and social service designees are not certified or licensed in Kansas, nor does Credentialing maintain a registry of these para-professionals. The definition(s) of these para-professionals are listed in the Kansas Adult Care Home regulations, which outline the requirements necessary to work in these capacities in an adult care home. Therefore, it is up to each facility to know the requirements for an activities director or social service designee, and to be sure each candidate meets the necessary requirements during the interview/employment process. The appropriate citations are Kansas Annotated Regulation (K.A.R.) 28-39-144 (a) for activities director, and K.A.R. 28-39-144 (xx) for social service designees.

Operator Training Program: The criteria for who can sponsor and teach an operator training course have been established, and the applications are being finalized. Courses **will** be approved in advance of the Assisted Living/Residential Health Care regulations being finalized. Sponsors interested in offering the course should contact Eric Aspegren at 913-296-6796 for more information.

Complaint Program Update

In January 1996, KDHE implemented some changes in the investigation of allegations of abuse, neglect, and exploitation. One of the changes involved having certain facilities that report allegations of abuse, neglect or exploitation complete the "Facility Complaint Investigation Report." This report is to be completed and submitted to the appropriate Regional Manager along with the facility's investigation of the allegation(s) within seven days of the date the complaint was initially reported to the Adult Care Complaint Program.

Frequently, these facility self-investigations constitute the basis of evidence used in an administrative hearing. For this reason, it is important that the investigation presents a clear picture of the alleged incident and provides any supportive documentation relative to the allegations. The reports need to include who, what, when, where, why, and witness statements, as appropriate. The witness statements are essential in determining if a finding of abuse, neglect, or exploitation can be made. Included with this *Fact Sheet* are copies of the "Facility Complaint Investigation Form," the "Alleged Perpetrator Information Form," and the "Complaint Investigation Witness Statement of Facts" (witness statement). The witness statement includes brief instructions to the witness as to how to write the statement. Please note that the witness statements are to be notarized.

Your assistance with this process has been very helpful and is appreciated. If you have any questions, please call the Complaint Program at (913) 296-1265.

Sample Nursing Home Emergency Plan

A sample nursing home emergency plan has been developed by Keith Stammer, CEM, Labette County Emergency Preparedness Coordinator. Some points addressed by the plan are of special interest to nursing home staff. These include: Contingency for Power Loss and Emergency Water, What to do in Case of Missing Residents, and What to do in Case of a Bomb Threat. For a copy of this plan, contact Mr. Stammer at (316) 795-2565 or write Labette County Emergency Preparedness, 718 5th Street, Oswego, Kansas 67356.

Below is an article submitted by Gordon Earhart with the Kansas State Fire Marshal's Office.

Reducing Your Facility's Life Safety Risk: Implementing Essential Programs

Facility owners and operators have the clear responsibility to provide the occupants of their facilities with an environment considered "safe." No one else can assume this responsibility. When people are in facilities outside their own home, they almost always assume they are "safe" and don't think about what might happen in an emergency event. They especially *assume they will be protected from harm during a fire event* in certain buildings which they perceive as being "safer" than most other buildings. Examples of these types of buildings include schools, hospitals, nursing homes, and public buildings. The owner/operator can have an enormous liability problem if they do not have programs in place to test, inspect, and maintain their life safety systems. In most cases, the risk of having people injured and killed in their facility can be effectively reduced if the systems put in place to protect the occupants are appropriately maintained.

Which systems protect people in buildings?

A building or facility contains may features which work together to make the building a complete **life safety system**. The designer must consider many things during the design stage including use, size, budget, weather, structural strength, location, requests from the owner, and most importantly, **the safety of the occupants**. The safety of the occupants is the primary reason to have building codes. Building codes serve as the main guide for providing the combination of features which yield an acceptably-safe building design or system.

Building systems which provide life safety protection for the occupants include two main types: **active and passive**.

Passive systems include fire and smoke barriers (which include walls and doors), construction type (protection against contributing fuel and also structural collapse), interior finish (the fuel on walls and ceilings), the actual size of the building, distances to exits, and the number of exits.

Active systems include fire alarm signalling systems, automatic fire/smoke detection systems, automatic smoke handling systems such as dampers and automatic air handling system shut down, and automatic suppression systems such as sprinklers. A smoke control system such as found in some large buildings is another example of an active system.

The building codes allow designers to "trade-off" certain features for other features. The trade usually involves trading a passive feature for an active feature. For example, designing a building with an automatic sprinkler system may allow the use of lighter, cheaper building materials and methods. This approach may allow a building to be constructed using "protected combustible" methods and materials rather than "protected non-combustible." The building may have a lowered requirement for smoke/fire barriers and may be larger than would be acceptable (in other words, "safe") without the sprinklers. Thus, **the automatic sprinkler system becomes a critical part of the building life safety system**. That is why it is important to make sure the sprinkler system can always be counted on to do its job when needed. You keep that assurance by providing a

sprinkler system inspection, testing, and maintenance program. Any passive systems must also be inspected, tested, and maintained according to an appropriate program. The "programmatic" approach is perhaps the most efficient method to ensure that essential life safety features of your facility are maintained appropriately. Facility owner/ operators can use a fire protection/life safety program to manage the risk of harm to occupants.

Elements of a Fire Protection Program

Management support is essential for the success of any risk management program. The foundation of a successful program is having management buy-in documented in writing, typically in a **policy statement** or other management document. Appropriate management support includes fiscal support. Since the safety of a facility's occupants is the direct responsibility of the owner/operator, anyone other than the top management who is responsible for guiding the life safety programs must be able to operate with the direct authority of the owner/operator. They must have the authority to direct the life safety/risk management programs without undue delays due to opposition or communication disadvantages. The life safety/risk management manager must have direct communication with top management.

Program goals or a mission statement should clearly define the purpose of the program. It should be easy to understand and should reflect the attitude of management concerning life safety and fire protection matters in their facility.

A **Statement of Requirements** defines WHAT your program uses for guidance. These are the technical guidance documents needed according to your specific systems and facility details.

Example statements include:

- "Automatic sprinkler systems shall be designed, installed, modified, inspected, tested, and maintained in accordance with NFPA 13 and NFPA 25."

- "Any changes in the building with the potential to impact life safety shall be designed by a licensed architect in accordance with the applicable building codes."

- "Fire alarm signalling systems shall be designed, installed, modified, inspected, tested, and maintained in accordance with NFPA 72."

Program Implementation may be in the form of procedures or other operational guidance documents. The implementation guidance should explain HOW the program is to work. It should include details such as who is authorized to perform program functions, levels of responsibility, who to contact for issues, who or what organization will perform what duties, what organizational route is to be followed for program work, and other pertinent details to make the program work in the organizational framework. The implementation details are highly specific according to your organizational structure.

The implementation of a fire protection/life safety program is the critical point where a program can be destined to either live of die; to facilitate a successful program the implementation must be simple, efficient, and effective. Most importantly, the program must work for those using it. Initial implementation of the program will likely include some level of personnel training and perhaps resources from outside the organization.

Program Management should be responsibility of a qualified individual. Most importantly, there should be a single point contact for life safety and fire protection issues. Ideally, the person responsible for direct program management should have a sound background in risk management including a knowledge of the applicable codes and regulations. A background in technical education and experience in the field of life safety and fire protection will save time and resources spent on fixing problems which could have easily been prevented. Other important skills include continuity of operations planning, risk assessment and specific risk mitigation skills and knowledge.

Although many organizations may not have the resources to maintain a full-time position, they still have the need for these skills from time to time. Some smaller organizations which considered a full-time fire protection/life safety person as being

too expensive have had the misfortune of having to pay out more in fines and facility modifications which could have been prevented by someone knowledgeably managing a fire protection/life safety program. As is always the case with safety and risk management issues, it is difficult to add up the savings of costs which never occur. The costs associated with not doing it right however, can be considerable.

The extra liability reduction and risk mitigation realized by having a qualified individual managing the program is difficult to quantify, but the experience of many industries and corporations shows this to be a wise value-added investment. Many organizations will not consider the option of losing their risk management personnel when "downsizing."

Products of the Program include both tangible and intangible items. Among the tangible products of a fire protection/life safety program are testing, inspection, and maintenance documents; contracts for service; results of assessments by outside authorities; potential lowered insurance costs; and savings realized from ensuring a dollar-for-dollar return on fire protection/life safety expenditures. An important physical product of a successful program is a "code footprint" - a schematic of the facility showing egress paths, exits, smoke and fire barriers, area separation walls, alarm and sprinkler details, and other life safety issues.

The intangible products of risk reduction through the program approach include savings from potential liability reduction (litigation avoidance); lower probability of loss of status from an untoward event which never happens; lowered probability of loss of income form business interruption; increased piece of mind for management with the knowledge someone is looking out for the fundamental life safety of the occupants; and the lowered probability of fines and penalties from outside authorities.

Although it may appear impossible at first glance, all sizes of facilities can benefit from risk management expertise, part-time or full-time. The goal is to enable the facility owner/operator to fulfill a fundamental obligation and responsibility: appropriate protection of the facility's occupants.

Below is an article submitted by the Office of Epidemiologic Services, KDHE.

Supplemental Infection Control Guidelines for the Care of Patients Colonized or Infected with Vancomycin-resistant Enterococci (VRE) in Long-Term Care Facilities

Purpose

These guidelines provide infection control information for hospitals, long-term care facilities, and home care agencies on strategies to prevent transmission of vancomycin-resistant enterococci (VRE) from colonized or infected patients. These supplement recommendations published by the Centers for Disease Control and Prevention (CDC) Hospital Infection Control Practices Advisory Committee (HICPAC) [1], and have been endorsed by the Kansas Department of Health and Environment. Guidance for long-term care facilities.and home health agencies, which was not covered by the HICPAC document, is included here.

This document solely addresses infection control strategies. Recommendations for surveillance, antibiotic utilization, and other aspects of an institutional plan for VRE prevention and control are covered in the HICPAC guidelines referenced at the end of this document.

Background

Enterococci are part of the normal flora of the intestinal tract and are a common cause of nosocomial infections. Since 1989, there has been an increase in the incidence of colonization and infection with VRE. Although VRE is not especially virulent, the lack of effective therapy for invasive infection and the potential for transfer of vancomycin resistance to other bacteria (i.e., Staphylococcus aureus) has made the control of VRE a public health concern.

In the next few years, a number of health care facilities and agencies can expect to encounter VRE in their patient population. Although a health care facility or agency may not have had a recognized case of VRE, this organism may be present in the

patient population as patients can be colonized with VRE and remain undetected. Although VRE is not a threat to health care workers, health care workers can transiently carry this organism and transmit it to other patients.

A. Admission and Transfer of Patients with VRE

The admission or transfer of patients should not be affected by VRE infection or colonization. All health care facilities and home care agencies must be prepared to implement appropriate infection control measures for patients infected or colonized with VRE and other resistant organisms. It is inappropriate to refuse admission of a patient based solely on the fact that VRE is present. Such action negatively affects patients by limiting access to the desired level of care, including hospitalization, and unnecessarily extends hospital stay beyond the period of medical care needed.

Today's health care environment must be viewed as a continuum where patients move back and forth across levels of care according to need. Open communication and sharing of information is essential to the provision of quality care. The infection control office in a receiving facility should be notified when a patient with VRE is being considered for admission or transfer so that preparations can be made, including reinforcing staff education on the control of VRE.

B. Principles of Controlling VRE Transmission

Strategies for controlling VRE transmission are essentially: confine the organism and control the vehicles of transmission that contribute to spread. The three most important elements in controlling VRE transmission are scrupulous handwashing, appropriate use of barrier precautions, and careful attention to environmental sanitation. Health care workers should always treat stool and urine as if they contain potential pathogens . Beyond this, control measures will be dictated by the type of facility in which care is provided and the vulnerability of its patient population. Patients vary in their susceptibility to becoming colonized with resistant organisms. Patients who have been on previous vancomycin and/or multiantimicrobial therapy, have severe underlying disease, are immunosuppressed, or have had intraabdominal surgery are at increased risk for VRE infection or colonization. Therefore, some patients in hospitals may have a higher risk of VRE infection. Recommendations for control of VRE consider these variations in risk and therefore hospital guidelines are more restrictive than those for other health care settings. Because VRE may be transmitted by contact with contaminated surfaces, greater attention is also placed on recognizing where the patient or health-care worker may have contacts which could result in transmission.
Factors that should routinely be considered when making decisions about infection control measures and room assignments include:

- intensity of care needs and degree of anticipated contact with excretions/secretions or wound drainage;
- the patient's ability to control secretions and excretions;
- the patient's level of activity and mobility, including expected interaction with other patients in a facility;
- presence of other patients who are infected or colonized with VRE;
- potential risk to roommates; and
- room availability.

The following recommendations are distinguished by the type of health care setting to which they apply. However, each facility or agency will need to adapt these guidelines on a case-by-case basis according to the situation and their previous experience with VRE.

C. LONG TERM CARE GUIDELINES.

1. Room/roommate selection. Resident placement decisions need to consider the risk/benefit and degree of disruption from changes in room assignment (considering all residents affected by a decision), the fact that colonization can persist indefinitely, and the resident's level of interaction within the facility. Residents who are incontinent of stool or urine or have wound drainage are at greatest risk for being a source of cross-contamination. When placing residents with VRE in multiple-bed rooms, roommates should not be severely immunocompromised, have indwelling lines or open wounds. VRE-positive residents who are incontinent of stool or urine and are likely to significantly contaminate the environment,

should be placed in a private room or cohorted with other VRE-positive residents, whenever possible.

2. Activity modifications. A long-term care facility is generally considered a resident's home. Residents with VRE should be allowed to ambulate, socialize normally, and participate in group activities as long as contaminated body substances are contained. Where appropriate, enhanced barrier protection to contain a contaminated body substance is preferred over restriction of the resident.

3. Handwashing. Use of an antimicrobial agent in the resident's room is recommended. (Antimicrobial agents are usually available in liquid form and are often referred to as "health-care personnel handwashes.") Health-care personnel should wash their hands before performing invasive procedures or touching wounds. Hands should be carefully washed after **all** resident care activities. Hands do not need to be washed routinely after casual contacts, such as a handshake or hug. The need for strict compliance with handwashing recommendations should be frequently reinforced. Where resident compliance is feasible, residents should also receive instructions on handwashing and frequent reinforcement.

4. Gloves and Gowns. In long term care settings there is a need for greater flexibility regarding decisions about the use of gloves and gowns. This will depend in part on the level of resident mobility and general compliance with hygienic practices, and the ability to contain secretions, excretions or drainage. Residents who are bedridden require a greater intensity of care and guidelines described above for hospitals may need to apply. When residents are more socially interactive and ambulatory, the need for gloves or gowns is limited to those situations involving direct contact with the contaminated body site. Nursing and medical staff should determine the most effective application of barrier concepts, balancing the need for infection control with promoting an optimal lifestyle for the resident. In all cases, clear guidance, consistency in approach, and rigorous enforcement is necessary. (Note: Even if gloves are worn, handwashing is also recommended because gloves can be perforated and bacteria can grow rapidly.)

5. Dedicated equipment. Equipment that is more likely to become implicated in transmission of VRE is less frequently used in nursing homes. Therefore, the need for dedicated equipment is less critical in long term care settings and not routinely recommended. However, residents should be evaluated on a case-by-case basis to determine where dedicated equipment may be indicated, i.e., residents who require a commode and who cannot be relied on to prevent contamination should have such equipment assigned.

6. Signs. Notification of isolation for VRE should be in keeping with the system currently used by the facility.

7. Housekeeping and laundry - Members of the custodial staff have an important role in controlling VRE transmission. They should be educated about VRE and taught to clean and disinfect environmental surfaces in the immediate vicinity of the resident, i.e., bed rails, door knobs, sinks, toilets, etc. (This does not apply to areas where the residents may be temporarily present , i.e.. lounge, waiting area). Cleaning of these surfaces should be performed daily and cleaning materials changed after use in that room. If resident care equipment is cleaned and disinfected by persons other than housekeeping staff, they too should be educated. Equipment that is typically cleaned only when the resident is discharged, (i.e., IV poles, pumps), should be placed on a schedule for routine cleaning. No specific cleaning interval is currently recommended, therefore, facilities should establish a schedule based on frequency of use, intensity of contact, and other factors that may be relevant to the situation. In most settings, it will not be necessary to modify linen and laundry handling practices as long as all such materials are treated as contaminated. However, personnel who are involved with stripping beds or who otherwise have direct contact with these materials should wear gloves and gowns

8. Discontinuation of Isolation Precautions. Because residents with VRE carry this organism indeterminently, long-term care facilities should not expect residents to have negative cultures for VRE before being accepted for admission.

We would like to acknowledge the New York State Department of Health for use of their supplemental guidelines on the control of vancomycin-resistant enterococci.

FOR MORE INFORMATION: call the Office of Epidemiologic Services, Kansas Department of Health and Environment at (913) 296-2951 or Patricia Maben in the Adult Care Home Program, Bureau of Adult and Child Care, Kansas Department of

Health and Environment (913) 296-1246. Reference:

Centers for Disease Control and Prevention. Recommendations for preventing the spread of vancomycin resistance: recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC). MMWR 1995;44(No. RR-12):1-13.

Resources for Quality Care

Urinary Incontinence in Adults: Acute and Chronic Management The Agency for Health Care Policy and Research has issued a revised clinical guideline update. The guideline has an excellent chapter on chronic intractable urinary incontinence. A copy of this guideline should be available to staff in all long term care facilities. Price and ordering information may be obtained by calling 1-202-512-1800. Ask for information on AHCPR Publication No. 96-0682.

Finding Nutritional Information on the Net

Facilities which have access to the World Wide Web will be able to access the following sites for nutrition related information.

American Diabetes Association - http://www.diabetes.org
Centers for Disease Control and Prevention - http://www.cdc.gov
Consumer Information Center - http://www.pueblo.gsa.gov
FDA Ctr for Food and Safety & Applied Nutrition - http://vm.cfsan.fda.gov/index.html

A recent article in the **Journal of the American Dietetic Association** has an extensive listing of web sites related to nutrition.

- "Individualized Care for Frail Elders: Theory and Practice," by Mary Beth Happ, Carter Catlett Williams, Neville E. Strumpf, and Sara Greene Burger, was published in the March 1996 issue of the **Journal of Gerontological Nursing**. The article includes valuable information on why individualized care is important for residents, and how to develop an individualized care plan that will meet a resident's needs. The entire March issue of the journal (Vol. 22, No. 3) is devoted to individualized care.

- "Malnutrition in Patients with Pressure Ulcers: Morbidity, Mortality, and Clinically Practical Assessments", by Eric A. Strauss and David J. Margolis, was published in the September/October 1966 issue of **Advances in Wound Care**. This article reviews the association between measurements of nutritional status and the presence, severity and healing of pressure ulcers. [ADV WOUND CARE 1996; 9(5):37-40]

- "Use and Perceived Effectiveness of Pressure Ulcer Treatments in Extended Care Facilities", by Rosemary G. Hoffman, Marilyn N. Pase, and Dawn M. Van Leeuwen, was published in the July/August 1996 issue of **Advances in Wound Care**. This article compares the perceived effectiveness of products with research based findings on the same products. [ADV WOUND CARE 1996;9(4):43-47]

- **Doing things: A Guide to Programming Activities for Persons with Alzheimer's Disease and Related Disorders**, by Jitka M. Zgola. This little book is full of ideas and concepts for providing individualized activities to persons with Alzheimer's Disease. The setting described is an adult day care center, but the activities are applicable to any long term care setting. This book is available through the state interlibrary loan system.

- **Improving Care of Residents with Diabetes** - The glycosylated hemoglobin (Hb) test measures the effectiveness of diabetes therapy for the preceding 4 to 6 weeks. Measuring blood or urine glucose reflects glucose control only at the time of collection.

How does the test work? Because glycosylation occurs at a constant rate during the 120 day life of an erythrocyte, glycosylated Hb levels reflect the average blood glucose level during the preceding 4 to 6 weeks. The test can measure three minor hemoglobins- A1a, A1b and A1c. Because hemoglobin A1c is present in the largest quantity is it the variant usually measured. It is important to mix the blood sample and the anticoagulant adequately for accurate test results.

Normal hemoglobin A1c is 4-6%. The American Diabetes Association has set a goal of less than 7% for persons with type II diabetes. When hemoglobin A1c is above 7 the care team can work with the resident to adjust diet, activity and medication to maintain the goal. Maintaining this goal significantly reduces long term complications of diabetes.

- **Memory Loss** - Research by Dharma Singh Khlasa, MD, president and medical director of the Alzheimer's Prevention Foundation demonstrates that memory loss is slowed through dietary intervention.

  The quality of brain longevity can be enhanced by increasing intake of complex carbohydrates, decreasing dietary fat, supplementing dietary intake with anti-oxidants and other B-vitamins and using behavioral conditioning exercises. The findings were presented at the International Congress on Alternative and Complementary Medicine in Washington,

  Compelling new evidence suggests that getting enough folic acid can prevent heart disease deaths in middle-age and older men and women. Foods rich in folic acid include dark leafy greens, orange juice, broccoli, peas, dried beans and fortified cereals. Journal of the American Medical Association June 26, 1996.

ANE ISSUE STATISTICS 4/1/96 to 6/30/96
Total Complaint Calls Assigned for Investigation - 613

ANE Investigations		Care Issues Investigated	
Total	**271**	**Total**	**290**
April	75	April	103
May	98	May	90
June	98	June	97

Alleged CNA/CMA Perpetrators - Administrative Review

Total Cases Reviewed	Admonishment Letter	Pending	To Registry	Dropped

*Licensure Category	Civil Penalties				Correction Orders			
	1996 Quarters							
	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Inadequate or inappropriate hygiene and skin care	5	6			32	49		
Inadequate or unqualified staffing	1	5			12	37		
Inoperable or inaccessible call system	-	-			2	2		
Inappropriate or unauthorized use of restraints	-	1			11	10		
Unsafe medication administration or storage	-	1			6	9		
Inadequate nursing services other than skin care	1	8			48	54		
Inadequate or inappropriate asepsis technique	-	-			8	11		
Inadequate or inappropriate dietary/nutritional services	2	6			23	21		
Unsafe storage of hazardous or toxic substances	-	-			2	2		
Failure to maintain equipment	2	1			9	3		
Resident right violations	3	3			7	15		
Unsafe high water temperature	2	-			9	2		
Inadequate hot water	-	-			-	-		
General sanitation and safety	1	1			4	18		
Other (including inappropriate admission)	-	2			-	14		
Inadequate rehabilitation services	-	-			1	-		
Civil Penalties	13	18						
Correction Orders					77	92		
Bans on Admission	3	3						
Denials	4	1						

***A correction order or civil penalty may consist of multiple issues summarized within the licensure categories above.**